STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155358	A. BUILDING 01 B. WING	06/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS MANOR CONVALESCENT & REHAB CENTER	3300 POPLAR ST TERRE HAUTE, IN47803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/16/11 Facility Number: 000249 Provider Number: 155358 AIM Number: 100267640 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Meadows Manor Convalescent & Rehab Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a basement was determined to be of	K0000	Please consider this Plan of Correction as allegation of compliance.Disclaimer:Meadows Manor Convalescent and Rehab Center does not believe and does not admit that any deficiencies existed before, during or after the survey. Meadows Manor Convalescent and Rehab Center reserves all right to contest the survey findings through informal dispute resolution, formal appeal proceedings. This plan of correction is not meant to establish any stand of care, contract obligation or position and Meadows Manor Convalescent and Rehab Center reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of potentially applicable peer review, quality assurance or self critical examination privileges which Meadows Manor Convalescent and Rehab Center does not waive, and reserves the right to assert in any administrative civil or criminal claim, action or proceeding. Meadows Manor Convalescent and Rehab Center offers its responses, credible allegation of compliance and plan of correction as part of its ongoing effort to provide quality care to its residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has the capacity for 89 and had a census of 75 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/22/11. The facility was found not in compliance with the aforementioned requirements as evidenced by:			
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to	K0021	The door coordinators will be replaced with a different brand of coordinator so that the smoke	07/31/2011

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	ensure 3 of 6 smoke barrier door sets were held open by a device which would allow the doors to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 71 residents in the east and west smoke compartments. Findings include: Based on observations with the maintenance director and maintenance man # 1 on 06/16/11 between 10:45 a.m. and 2:45 p.m., the smoke barrier door sets were equipped with door coordinators. Upon testing the coordinators on the smoke barrier door sets near rooms 201, 229, and 120; each set of doors was prevented from closing when the doors hit the door coordinators attached to the tops of the door frames. Maintenance man # 1 said at the time of observation, the doors would close if released in the proper sequence. The doors failed to close when the fire alarm was tested at 2:55 p.m. on 06/16/11. The maintenance director agreed at the time of observations, the coordinators		barrier door sets will close properly. See attached acknowledgement from Crossroads Door & Hardware, Inc., dated June 24, 2011.This item could potentially affect all residents in the facility, as do all areas of fire safety.The Facility Maintenance Supervisor will be the responsible person and will monitor by visibly inspecting the doors operation each week by using the Fire Alarm Test chart to ensure that this type of finding does not recur. (See attached Fire Alarm Test) Date of Completion 7-31-11	

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	were not functioning as designed when they prevented the doors from closing. 3.1-19(b)			
K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted at unexpected times during 10 of 12 fire drills. This deficient practice affects all occupants. Findings include: Based on a review of Fire Drill Reports provided for the past year with the maintenance director on 06/16/11 at 10:55 a.m., fire drills were conducted between the 27th and 31st day of the month. Fire drill times varied less than one hour on the following drills: a. During the first shift on	K0050	Fire drills will be held at unexpected times under varying conditions at least quarterly on each shift.This item could potentially affect all residents in the facility, as do all areas of fire safety.The Facility Maintenance Supervisor will monitor monthly by use of the Fire Alarm Test chart (see attached chart). The Maintenance Director will be the responsible person and will monitor by visibly monitoring the Fire Drill Test char to ensure that this finding does not recur.Date of completion 7-16-11	07/16/2011

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	07/30/10 at 10:55 a.m., 10/28/10 at 10:30 a.m. and 4/29/11 at 11:00 a.m.; b. During the second shift on 08/31/10 at 4:00 p.m., 02/28/11 at 4:15 p.m. and 05/27/11 at 4:15 p.m. A fire drill conducted on 11/30/10 noted "shift 2-10" but a definite time was not recorded; c. During the third shift on 12/30/10 at 11:00 p.m. and on 03/31/11 and 05/31/11 at 11:15 p.m. The drill conducted during the first quarter on the first shift of 2011 and last quarter on the night shift of 2010 were the only drills which appeared to have been held at unexpected times. The maintenance director agreed at the time of record review, the fire drill times should have been more varied. 3.1-19(b) 3.1-51(c)			

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K0054 SS=F	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Based on record review and interview, the facility failed to ensure 9 of 10 smoke detectors had functional testing done annually. LSC Section 9.6.1.3 says the provisions of 9.6 cover the basic functions of the fire alarm system, including fire detection systems. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, Table 7-3.2 (Testing Frequencies) requires a functional test of the smoke detectors annually. NFPA 72, 7-5.2.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice affects all occupants. Findings include: Based on review of fire system smoke detector inspection and testing records with the maintenance director on 06/16/11 at 1:25 p.m., the facility contractor's annual inspection report dated 07/21/10 failed to	K0054	Smoke detectors functional test will be done annually.This item could potentially affect all residents in the facility, as do all areas of fire safety.The Facility Maintenance Supervisor will be the responsible person and will monitor by visibly monitoring the Facility Life Safety Inspections Book to ensure that this finding does not recur.	07/16/2011

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	include a list of the smoke detectors, their function test and the results. The last complete record was included on a sensitivity Smoke Detector Test Report dated 07/21/09. The maintenance director agreed at the time of record review, there was no way to determine whether the smoke detectors were working based upon the records provided. 3.1-19(b)			
K0069 SS=D	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-2.1 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by	K0069	The range hood's fire extinguishing equipment will be inspected every 6 months by properly trained and qualified persons.This item could potentially affect all residents in the facility, as do all areas of fire safety. The Maintenance Director will be the responsible person and will monitor by visibly checking the Facility Life Safety Inspections Book to ensure that this finding does not recur.	07/16/2011

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	properly trained and qualified persons. Furthermore, NFPA 96, 8-2.1.1 requires actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, fire-actuated dampers, etc., shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice affects occupants of the kitchen where 4 staff were observed. Findings include: Based on a review of the Restaurant Systems Work Orders, the inspection for the commercial range fire suppression system records with the maintenance director on 06/16/11 at 11:45 a.m., the most recent inspection and service record for the commercial range hood fire equipment system was dated 12/17/10. No documentation for a subsequent six month inspection was found. The maintenance director said at the time of record review, the contractor was "late."			

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K0130 SS=D	3.1-19(b) OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 4 of 4 service water heaters and boilers had unexpired certificates of inspection. LSC 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice occupants of basement where 3 staff were working in the laundry. Findings include: Based on observation of the basement boiler/mechanical room with the maintenance director on 06/16/11 between 2:55 and 3:10 p.m., the posted certificates of inspection for four service water heaters and boilers in the basement mechanical room expired 05/04/11. The maintenance director said at the	K0130	We are not in violation of this code. All of our boilers and pressure vessels are up-to-date and do not expire until May 4, 2012.The Life Safety Inspector must have misread the year on the certificates or looked at the issued date and not the expiration date.	07/31/2011

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	time of observation, the vessels had been inspected but there was nothing to show anyone had done the inspections. 3.1-19(b)			
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on interview and record review, the facility failed to provide complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS(Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 110, 5-13.2.5 requires a full	K0144	The facility will exercise monthly the generator under operating conditions for not less than 30 percent of the emergency power supply nameplate rating, for a minimum of 30 minutes.The Facility Maintenance person misinterpreted the load test information from NRK Electrical. The generator was exercised at not less than 30 percent of its rating.This item could potentially affect all residents in the facility, as do all areas of fire safety.The Facility Maintenance Supervisor will monitor monthly by use of the maintenance generator chart. (See attached chart.) The Maintenance Director will be the responsible person and will monitor by visibly monitoring the generator test char to ensure that this finding does not recur.	07/16/2011

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	load shall be applied for a 2 hour load test. NFPA 110, 5-13.2.7 requires specific data shall be recorded at first load acceptance and every 15 minutes thereafter until the completion of the 2 hour test period. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affects all occupants. Findings include: Based on review of the East Generator Test records provided by the maintenance director on 06/16/11 at 2:05 p.m., the records included monthly load testing of the emergency generator which occurs at less than the 30 percent minimum load required. A letter from the generator contractor dated 07/26/10 verified a load test was done on the emergency generator and noted only one load test reading for each of two phases. The letter did not include the			

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	required data recorded at 15 minute intervals for the duration of the test. The maintenance director said at the time of record review, he had no further information for the load test and would request the specific data be provided by the contractor. 3.1-19(b)			
K0147 SS=E	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff and 43 residents on the east wing. Findings include: Based on observations with the maintenance director on 06/16/11 at 2:50 p.m., power strip	K0147	Extension cords and work lights will be removed fro the attic area.This item could potentially affect all residents in the facility, as do all areas of fire safety.The Maintenance Director will be the responsible person and will monitor by visible overseeing all maintenance performed in the attic areas.	07/16/2011

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	extension cords were plugged into two work lights hanging in the attic from the rafters above the east smoke compartment. No work was in progress in the area. The maintenance director said at the time of observation, the lights were left plugged into the hanging lights to provide lighting whenever it was necessary to work in the attic. He said other compartments in the attic had lighting hard wired in. 3.1-19(b)			